REPORT BY THE

AUDITOR GENERAL

OF CALIFORNIA

MEDI-CAL CAN REDUCE CERTAIN PROGRAM AND ADMINISTRATIVE EXPENDITURES

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OFFICE OF THE AUDITOR GENERAL

TO THE

JOINT LEGISLATIVE AUDIT COMMITTEE

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MEDI-CAL CAN REDUCE CERTAIN PROGRAM AND ADMINISTRATIVE EXPENDITURES

MAY 1982

California Legislature

Joint Legislative Audit Committee

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May 25, 1982

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The Honorable President pro Tempore of the Senate
The Honorable Speaker of the Assembly
The Honorable Members of the Senate and the
Assembly of the Legislature of California

Members of the Legislature:

Transmitted herewith is the Auditor General's report on Medi-Cal eligibility for the medically needy and the medically indigent. The 1981-82 estimated state expenditures are $564 million for the 400,000 medically needy and $823 million for 380,000 medically indigent. Eligibility defined by state and federal regulations is determined by the counties' social service departments. Counties are reimbursed out of the $101 million of state and $50 million of federal funds provided for the administration of eligibility determinations. This report does not include comments on the eligibility of the 2.4 million persons receiving $2.6 billion of Medi-Cal benefits who are automatically eligible as recipients of welfare cash grants.

The auditors sampled cases for Medi-Cal eligibility in three counties, Los Angeles, Monterey, and Sacramento. Counties' failure to verify claimants income within the required 60-day time period and when appropriate to discontinue eligibility could and probably does result in payment of claims for ineligible persons. This condition exists because of deficiencies in the Department of Health Services regulations and in the counties compliance with them.

Los Angeles County discontinued processing a required quarterly status report which is used to provide information affecting the continued eligibility of Medi-Cal applicants. A substitute mailer does not provide information on changes in income and expenses which could affect the beneficiary's share of costs or eligibility. Also, the State is reimbursing Los Angeles County for eligibility systems run by both the County Departments of Health Services and Public Social Services. It is estimated that $2.1 million could be saved by the State by eliminating duplicate processing.

The report also points out that the federal agency's interpretation of federal regulations disagrees with a special income deduction which is allowed by state law. This deduction covers approximately 31,500 aged, blind or disabled medically needy individuals. These persons have enough income to be excluded from receiving SSI/SSP grants, therefore, the deduction is allowed to provide them Medi-Cal benefits without depleting comparable income available for other living expenses. This deduction costs the State $18 million each year. Under the federal interpretation of the regulations this allowance constitutes an error and could increase the State's error rate enough to cause the loss of $11 million of federal funds.

The State Department of Health in cooperation with the counties should make an all-out effort to reduce the error rate by the prompt verification and continued monitoring of applicants' income. Applied statewide, this could save millions in eliminating the payment of claims for ineligible persons. Also, with a lower error rate, the State would not risk the loss of federal funds for providing equitable benefits to the partially self-supporting medically needy aged, blind, or disabled persons. An effort should be made to clarify the interpretation of federal and state regulations to eliminate this exception.

Respectfully submitted,

WALTER M. INGALLS
Chairman, Joint Legislative
Audit Committee

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SUMMARY

As a federal/state health-care program, Medi-Cal pays for all or part of the medical expenses of approximately 3 million Californians. Individuals who receive welfare assistance in the form of cash grants are automatically eligible for Medi-Cal. In addition, medically needy and medically indigent individuals and families receive Medi-Cal benefits. The medically needy are persons who meet all the requirements for welfare assistance, except the income requirement, but who do not receive cash grants. The medically indigent beneficiaries include persons under 65 years of age whose medical needs exceed their ability to pay. Since these two groups do not receive cash grants, they must apply for Medi-Cal, and they constitute what is known as the medical-assistance-only category. The State Department of Health Services administers the Medi-Cal program for medically needy and medically indigent individuals and families. County social service departments determine the eligibility of these beneficiaries for Medi-Cal coverage.

By making changes in the policies and methods that the State and the counties use to determine the eligibility of medical-assistance-only beneficiaries, the State could reduce

the number of errors in determining eligibility, reduce expenditures on associated medical services, and avoid potential federal disallowances of funding.

Specifically, the State can reduce expenditures for medical-assistance-only beneficiaries by improving the methods used to determine an individual's eligibility. Existing regulations regarding income verification are not sufficiently restrictive. Furthermore, because counties are not adequately complying with existing regulations, they are experiencing significant error rates in determining the eligibility of medically needy and medically indigent beneficiaries. Also, the Department of Health Services' monitoring program has not conducted the necessary case reviews that guide the technical assistance that the department provides to counties to help eliminate errors.

A statutory change could reduce program expenditures also. The State currently provides a special income deduction to certain medically needy persons that does not comply with federal regulations and that may result in the federal government's disallowing millions of dollars in federal funding.

The eligibility of Medi-Cal applicants and beneficiaries is constantly changing because of such factors as mobility and unemployment. Consequently, the Department of Health Services attempts to ensure that counties discontinue the eligibility of individuals who no longer qualify for the program. The department requires counties to obtain information at least quarterly about changes in beneficiaries' income, living arrangements, and other items that could affect eligibility. The counties revise the share of medical costs that beneficiaries must pay when their incomes or expenses have changed.

Los Angeles County discontinued processing the required quarterly status reports in 1981, claiming that the processing costs exceeded the benefits derived from the reports. It has proposed an alternate method, a mailer, that may be as effective as the quarterly status reports are in discontinuing the eligibility of beneficiaries. However, the mailer does not acquire information about changes in a beneficiary's income and expenses that affect the beneficiary's share of cost. The quarterly status reports do acquire information that can change a beneficiary's share of cost, but the cost of obtaining this information may exceed its benefit. Sufficient information and analysis are not available to support the use of either the mailer or the quarterly status report.

In addition to paying for medical services provided to beneficiaries, the State also spends more than $100 million a year to administer the portion of the Medi-Cal program that provides services to medical-assistance-only beneficiaries. Since 1972 the State has reimbursed Los Angeles County for costs associated with administering two separate systems for determining the eligibility of medical-assistance-only beneficiaries. The Los Angeles County Department of Health Services operates one system, processing applications taken from individuals admitted to the county hospitals. The Department of Public Social Services administers the other system, processing applications in its district offices.

The Legislature has limited the reimbursements made to the Los Angeles County Department of Health Services for processing applications in the county hospitals. However, the State Department of Health Services is still reimbursing Los Angeles County for the excess costs that result from the two systems. We estimate that the State could save approximately $2.1 million in administrative costs if it did not subsidize Los Angeles County for the duplication created by the present system for processing Medi-Cal applications.

To reduce the number of errors in determining eligibility, the State Department of Health Services should strengthen regulations by requiring counties to verify accurately the income of applicants within the required 60-day time period. Additionally, the department should review the appropriateness of the 60-day deadline and determine whether it could be reduced. To minimize potential federal disallowances of funds, the Legislature may wish to consider eliminating the special income deduction that currently applies to certain medically needy individuals.

Furthermore, the Department of Health Services should obtain sufficient data to determine and evaluate the costs and benefits of the quarterly status report in obtaining information about the change in the status of beneficiaries. The department could then determine if the cost to process the quarterly status reports exceeds the benefits they provide. However, any alternate system that the department considers should maintain sufficient contact with beneficiaries.

Finally, the Department of Health Services should develop a method for reimbursing Los Angeles County that does not subsidize the county for the duplication created by the two systems for processing Medi-Cal applications.

INTRODUCTION

In response to Chapter 102, Statutes of 1981 (Assembly Bill 251), we have reviewed the effectiveness and efficiency of the state and county programs that are responsible for determining the Medi-Cal eligibility of medically needy and medically indigent beneficiaries. This audit was conducted under the authority vested in the Auditor General by Sections 10527 through 10528 of the Government Code.

This section provides background information about the Medi-Cal program and the beneficiaries who are eligible for Medi-Cal. It also summarizes the cost of medical services provided to the beneficiaries (program costs) and the cost of the counties' administration of the program (administrative costs). Finally, this section explains the scope and methodology of our review.

BACKGROUND

Medi-Cal, which began in 1966, is a joint federal/state health-care program authorized by Title XIX of the Social Security Act. The program pays all or part of the medical expenses of approximately three million Californians.

Individuals who receive welfare assistance in the form of cash grants are automatically eligible for Medi-Cal. These individuals include recipients under the Aid to Families with Dependent Children (AFDC) and Supplemental Security Income/State Supplementary Payment programs (SSI/SSP). AFDC recipients are dependent children and related adults whose eligibility for Medi-Cal is determined by county welfare departments. SSI/SSP recipients are aged, blind, and disabled persons; the federal government determines their eligibility.

In addition, two other groups are eligible for health-care services under Medi-Cal: the medically needy and the medically indigent. These groups are the subject of this report. Since these two groups do not receive cash grants, they constitute what is commonly referred to as the "medical-assistance-only" category. The medically needy are families or individuals who would otherwise be eligible for AFDC or SSI/SSP (that is, families with dependent children and families or individuals who are aged, blind, or disabled) but who do not receive cash grants. These families or individuals do not receive cash grants because their incomes exceed the level allowed by cash-grant programs or because they choose not to apply for the cash grants. They meet all of the other requirements of the cash-grant program. Medically needy

individuals or families are considered to be "linked" to a cash-assistance program; therefore, the benefits they receive are paid for in part by federal funds.

The medically indigent, on the other hand, include persons who cannot be linked to a cash-assistance program. They are under 65 years old and have medical needs that exceed their ability to pay. "Ability" in this case is based on income and resource standards. The medically indigent consist of two groups: medically indigent children, who qualify for federal funds, and medically indigent adults, who qualify only for state funds. For these two groups, eligibility is determined by comparing an individual's or a family's medical expenses with the income available to meet those expenses. To determine how much an eligible individual could spend for medical expenses, the Medi-Cal program deducts an amount for living expenses from the individual's or family's income. If the remaining income that can be devoted to medical expenses is insufficient to defray these expenses, the Medi-Cal program pays the difference.

Medically Indigent
Adult Recipients

Medi-Cal did not cover medically indigent persons until the Medi-Cal Reform Act of 1971 was passed. Before that time, medically indigent adults, referred to as the "working poor," were forced to rely for medical care on charitable institutions, especially county hospitals.

The medically indigent adult population is not eligible for federal assistance under the Medi-Cal program. Because the federal government pays no part of the cost for this group, the State must defray the full cost of the services provided. In fiscal year 1979-80, approximately 65 percent of the total state expenditures for medically indigent adults went for hospital inpatient care. County hospitals provided about one-third of this care and received about 22 percent of the total General Fund expenditures for medically indigent adults.

Table 1 on the following page indicates the average monthly number of persons who are eligible for Medi-Cal in each category of aid.

TABLE 1

AVERAGE MONTHLY NUMBER
OF PERSONS ELIGIBLE FOR MEDI-CAL
FOR FISCAL YEARS 1977-78 TO 1981-82

Type of Beneficiary	Number of Persons 1977-78 (Actual)	1978-79 (Actual)	1979-80 (Actual)	1980-81 (Actual)	1981-82 (Estimated)	Change 1981-82 over 1980-81
Cash Grant						
Aged	328,207	324,548	318,213	312,258	305,900	-2.0%
Blind	12,850	12,901	16,817	17,874	18,000	0.7%
Disabled	348,096	360,712	368,980	374,631	378,600	1.1%
AFDC	1,473,148	1,427,548	1,418,425	1,534,290	1,577,700	2.8%
Medically Needy	325,242	326,321	339,505	358,669	408,200	13.8%
Medically Indigent						
Children	129,026	116,495	109,055	113,915	112,000	-1.7%
Adults	287,596	259,166	247,051	265,691	270,900	2.0%
Other (refugees, etc.)	23,750	15,078	25,843	53,763	61,100	13.6%
Total	2,927,915	2,842,769	2,843,889	3,031,091	3,132,400	--
Change from previous year	4.3%	-2.9%	--	6.6%	--	3.3%

The Budget for
Medical-Assistance-Only
Beneficiaries

Medi-Cal recipients are entitled to a full range of health services. Although federal regulations require the provision of many services, the State provides other services at its discretion. In fiscal year 1981-82, the total estimated expenditure for all of these services was $4.6 billion. The State General Fund will provide approximately $2.7 billion of these estimated expenditures, and federal funds will provide the balance. Approximately $564.6 million goes to services for the medically needy, and $823.4 million goes to services for the medically indigent.

In addition to funding medical care, the State also partially funds the administrative costs of the Medi-Cal program. Counties determine the eligibility of medically needy and medically indigent applicants for the program, and the administrative costs of making these determinations are reimbursed entirely by state and federal funds. The State and the federal government share the costs of determining eligibility for the medically needy and medically indigent children. However, the State pays 100 percent of the costs of determining eligibility for the medically indigent adult category. The State's overall share of costs for determining

Medi-Cal eligibility for the medically needy and medically indigent is approximately 67 percent. The federal share of these costs is about 33 percent.

The Department of Health Services' proposed expenditures for determining Medi-Cal eligibility in fiscal year 1981-82 total approximately $151.2 million. The General Fund share of this amount is about $101.4 million, with the remaining funds coming from the federal government.

The Responsibility for Administering the Medical-Assistance-Only Program

The State Department of Health Services (department) and the counties jointly administer the medical-assistance-only program. The department develops procedures and policies for determining eligibility, but the counties actually determine the eligibility of medically needy and medically indigent applicants. The department's County Liaison Section also monitors the counties' activities by sampling and reviewing case files and by providing technical assistance. The department's Quality Control Section also monitors the counties' activities through federally mandated case reviews that detect errors and determine error rates.

SCOPE AND METHODOLOGY

We evaluated the effectiveness and efficiency of determining the eligibility of medical-assistance-only beneficiaries in Sacramento County, Los Angeles County, and Monterey County. To complete this evaluation, we reviewed federal and state laws and the regulations governing eligibility for Medi-Cal. We also reviewed state and county procedures for administering the Medi-Cal program.

To evaluate how accurately the counties determine Medi-Cal eligibility and to compute the share of medical expenses that beneficiaries pay (known as "share of cost"), we randomly selected and reviewed a total of 380 Medi-Cal cases eligible in November 1981 in the three counties we visited. One-half of the cases reviewed in each county involved medically needy and medically indigent children, cases that receive both federal and state funding. The other half of the cases reviewed involved medically indigent adults, cases that receive only state funding.

Finally, we reviewed and analyzed the claims made by counties for the reimbursement of administrative expenditures.

Limitations

In conducting our case reviews, we evaluated only a sample of factors that cause either inappropriate eligibility or an understated share of cost by beneficiaries. As a result, our projected error rates are conservative. Also, because data on the charges billed to Medi-Cal are not available for four to six months after a beneficiary is determined to be eligible, we were unable to identify the actual misspent dollars that are attributable to the cases we reviewed. (As part of its quality control audits, however, the department reviews all the factors affecting eligibility and, based on paid-claim files, determines misspent dollars. Finally, because we reviewed the Medi-Cal program in only three counties--Sacramento, Los Angeles, and Monterey--our results are not representative of the State as a whole.

CHAPTER I

OPPORTUNITIES EXIST TO REDUCE MEDI-CAL PROGRAM EXPENDITURES IN MEDICAL-ASSISTANCE-ONLY PROGRAMS

The State spends most of its Medi-Cal budget to pay for medical services provided to beneficiaries rather than for administering the Medi-Cal program. While the state and federal governments share the cost of services provided to most beneficiaries, the State pays the total cost of services for the medically indigent adults. By making changes in the policies and methods that the State and the counties currently use to determine the eligibility of medical-assistance-only beneficiaries, the State could reduce the number of errors made in determining eligibility, reduce expenditures on associated medical services, and avoid potential federal disallowances of funding.

Specifically, the State can reduce the expenditures for medical-assistance-only beneficiaries by improving the methods used to determine an individual's eligibility. Furthermore, because counties are not adequately complying with existing regulations, they are experiencing significant error rates in determining the eligibility of medical-assistance-only beneficiaries. For example, the sampled cases in one county

revealed an error rate of between 4.8 and 15.2 percent. Based on the error rate alone, we cannot determine how much money was inappropriately spent; however, each error made in determining eligibility creates the potential for an ineligible individual or family to receive Medi-Cal benefits and inappropriately increase the State's cost of medical services. The County Liaison Section of the State Department of Health Services (department) has not conducted the necessary case reviews that guide the technical assistance which the department provides to the counties to help them reduce errors.

A statutory change could reduce program expenditures also. The State currently provides a special income deduction to certain medically needy persons that does not comply with federal regulations and that may result in the federal government's disallowing millions of dollars in federal funding. The federal government claims that California's special income deduction has always violated federal regulations. Based on this interpretation, federal quality control reviewers assess an error for any case in which the special income deduction is granted and affects the beneficiary's share of cost. Department officials estimate that this interpretation has increased California's error rate from approximately 5.5 percent to 7 percent for the review period between April and September 1980. This increased error

rate has resulted in an attempt by the federal government to disallow approximately $11 million of federal funding. According to department analysts, the elimination of the special income deduction would affect an estimated 31,540 aged, blind, and disabled medically needy beneficiaries who do not receive an SSI/SSP cash grant, although eliminating the deduction would also reduce program costs by an estimated $18.9 million.

IMPROVEMENTS NEEDED IN DETERMINING ELIGIBILITY

The State can reduce its expenditures for medical services for the medically needy and medically indigent by determining the eligibility of these beneficiaries more accurately. In determining eligibility, some counties are making significant errors that can be reduced by their complying more adequately to existing regulations. More restrictive regulations governing income verification will help ensure that applicants who do not provide income verification will not receive Medi-Cal benefits. Improving the Department of Health Services' monitoring and technical assistance will also help to reduce errors. These improvements will decrease the number of instances of inappropriate eligibility and, in turn, reduce the State's expenditures for medical services.

To ascertain the counties' effectiveness in determining eligibility, we randomly selected 380 Medi-Cal cases. We reviewed the case files to determine the frequency and types of errors and to determine whether the errors resulted in granting eligibility to persons who were not eligible or whether the errors resulted in a beneficiary's contributing too little toward his or her medical expenses. (A beneficiary's contribution is commonly referred to as "share of cost.")

Errors affecting eligibility or resulting in an understated share of cost occurred in 6.2 percent of the cases sampled in Los Angeles County. In Sacramento County, the rate of error in the sample of cases was 9 percent. Based on the sample number of such cases in Sacramento County, we estimate that the error rate in the total number of cases in that county lies between 4.8 percent and 15.2 percent. In Los Angeles County and Monterey County, the error rate in the total number of cases was lower. The following table displays the error rate in the sample cases and the estimated error rates in the total number of cases in the three counties.* Our estimates are conservative because we did not review all the factors that may affect eligibility.

* The confidence level of the range of errors projected in the total population is 90 percent; we project the minimum error rate or the maximum error rate in the total population with 95 percent assurance.

TABLE 2

ERROR RATES
IN TOTAL NUMBER OF CASES, NOVEMBER 1981
(BASED ON ERROR RATES IN SAMPLE CASES)

County	Error Rate In Sample Cases	Error Rate in Total Number of Cases	
		At Least	Not More Than
Los Angeles	6.2%	3.4%	9.8%
Monterey	8.8%	4.9%	15.1%
Sacramento	9.0%	4.8%	15.2%

From the figures shown above, we can project that in Los Angeles County, for example, between 5,273 and 15,200 cases may contain errors in eligibility or share of cost. Although the error rate in Monterey County is higher than that of Los Angeles County, the cases in error (between 198 and 610) are significantly fewer because the county itself is much smaller than Los Angeles County.

The department's Quality Control and Evaluation Branch (branch) reports error rates that are somewhat larger than ours. For the review period from April through September 1981, the branch reported a statewide case-error rate for medically needy and medically indigent children of

15.28 percent. For the three counties we reviewed, the branch reported error rates of between 15.41 percent and 23.81 percent during the same period (April through September 1981.)*

The actual costs of these errors cannot be determined until Medi-Cal payments are recorded. However, each error, whether it results in inappropriate eligibility or understated share of cost, potentially increases the State's cost of medical services.

Need for Improved Regulations

State regulations allow counties to grant eligibility for 60 days to an individual who qualifies for the program based upon a signed statement of estimated income and other information provided in the application form. Most of the errors in determining eligibility that we found in our review occurred because counties did not verify applicants' income. Changes in the regulations and procedures could reduce some of these errors and reduce program expenditures.

* The department indicated that the error rates in Monterey County and Sacramento County are not statistically valid because the statewide sample does not include enough cases from these counties.

The State Department of Health Services develops regulations and procedures for the counties to use in administering the Medi-Cal program. These regulations, contained in the department's eligibility manual, define the conditions governing Medi-Cal eligibility. Based upon state regulations and procedures, counties may also develop procedures to administer the program. Both the state regulations and the county procedures need to be improved.

Before an individual can receive Medi-Cal, the individual must meet certain criteria. (These same criteria apply to a family.) Real and personal property cannot exceed a specified limit, and if income exceeds the amount allowed for living expenses, the individual must pay for or be obligated to pay for a share of the costs of medical care. Also, certain factors (income, for example) that affect eligibility must be verified.

If a county does not receive the verification of income within 60 days after receiving the application, it must discontinue the eligibility. To ensure that beneficiaries continue to meet eligibility requirements, the counties process a status report at least quarterly in which the beneficiary provides requested information about income, expenses, and

living arrangements. If the beneficiary does not return the status report, the county should, according to state regulations, discontinue the beneficiary's eligibility.

In our review of cases, we found that the counties are not adequately verifying income and that they are not discontinuing eligibility when beneficiaries do not provide income verification or do not return the status report. In the counties we visited, most of these errors occurred because the county did not receive the verification of income. Most of the errors that affected an individual's eligibility resulted from the county workers' failure to discontinue eligibility when the beneficiary either did not provide verification of income or failed to return the quarterly status report.

The state regulations regarding income verification allow the counties considerable flexibility in determining eligibility for the Medi-Cal program. This flexibility enables individuals to receive Medi-Cal benefits for at least 60 days (up to 90 days in some cases) without ever verifying their statement of estimated income. Although a county must verify income, Title 22, Section 50168, of the California Administrative Code allows a county 60 days after it receives the application, but not necessarily before the approval of eligibility, to obtain verification of an applicant's income. This process of delayed verification leads to situations in

which counties may grant eligibility and then discontinue eligibility without the applicant ever having provided verification of income. Because state regulations allow an applicant 60 days to verify income, the State pays for 60 days (up to 90 days, depending on the specific timing) of Medi-Cal benefits for any beneficiary who completes an application and provides a signed statement of estimated income.*

Based upon the state regulation, Los Angeles County has developed the "approved pending verification" procedure, which is one example of the practice of granting eligibility without verifying an applicant's income. In Los Angeles County, hospital employees process Medi-Cal applications that are received from those individuals admitted to the county hospitals who appear to be eligible for Medi-Cal benefits. Under the "approved pending verification" procedure, the patient completes the Medi-Cal application and a declaration of estimated income. The hospital employee then advises the patient that he or she must provide verification of this income or be ineligible to receive Medi-Cal payments beyond the period applicable to this process.

* This regulation results in 60 to 90 days of eligibility because a beneficiary who is eligible for one day of a month receives benefits for the entire month. For example, eligibility could be granted on March 15 and terminated 60 days later on May 15. However, the beneficiary is eligible for all of March, April and May, or approximately 90 days.

If the applicant provides the verification, the case is processed as a regular application with benefits that continue beyond the 60-day period. If the applicant does not provide the requested income information, however, the county processes the application pending verification of income. That is, the county simultaneously approves Medi-Cal coverage for 60 days and discontinues eligibility beyond those 60 days because of the applicant's failure to provide income verification. For example, Beneficiary J enters the county hospital on June 5th and has a baby on June 6th. She completes a Medi-Cal application, provides a signed statement of estimated income, and agrees to provide verification of her income. However, she never provides this verification. The hospital worker completes J's application, grants her Medi-Cal eligibility for 60 days effective June 1st (pending verification), and simultaneously discontinues her benefits the last day of August because J failed to provide verification of income.

To determine the effect of the "approved pending verification" procedures, we reviewed 77 cases of the November 1981 caseload in the Los Angeles County hospital system. Approximately one-half of the applications reviewed had been approved pending verification, and 92 percent of those approved pending verification were subsequently discontinued for failure to provide verification of income. We can, therefore, project that at least 1,314 of the November 1981 caseload of 3,405

cases were approved pending verification. Of these, at least 85 percent (1,117 applications) would have been approved and then discontinued without the applicants' ever having provided any income verification.*

The Los Angeles County Department of Health Services' statistics are consistent with these findings. For the six-month period ending January 1982, hospital employees denied 19 percent of the regular applications in which income was verified. However, they denied only 3 percent of the "approved pending verification" applications. That is, Medi-Cal coverage was denied six times more frequently for applications with verified income than for applications that were approved pending verification of income. This statistic suggests that the State may be paying for medical services provided to some beneficiaries who may not have been granted eligibility had they been required to verify their income immediately.

The State could save money in the Medi-Cal program if the regulations required beneficiaries to verify their income sooner than 60 days after the date of application. No apparent justification for the 60-day limit exists; moreover, the longer the period that the State and counties provide for applicants

* These statistics are calculated based upon a 95 percent confidence level.

to verify income, the greater the potential will be for services being granted to an individual whom the county may ultimately find to be ineligible.

Need for Improved Monitoring

The State Department of Health Services' monitoring program has not conducted the necessary case reviews that guide the technical assistance which the department provides to the counties to help them reduce errors. The staff of the department's County Liaison Section contact the counties directly to determine specific problems, to provide training and technical assistance, and to ensure that counties correct all of the identified problems. In order to fulfill its monitoring responsibilities, the County Liaison Section periodically has its program consultants review cases for compliance with regulations and for accuracy in determining eligibility.

The department uses these case reviews to identify specific problems so that it can provide the appropriate training and suggest the proper corrective action. According to the department's own procedures, staff are supposed to review county cases regularly. The County Liaison Section groups counties according to Medi-Cal population, and it determines the frequency of case reviews based upon a county's

total number of medical-assistance-only beneficiaries. Large and medium-sized counties have 5,000 to 250,000 beneficiaries and are reviewed quarterly. The small counties, with 1,500 to 5,000 beneficiaries, are reviewed semi-annually, and the very small counties, with fewer than 1,500 beneficiaries, are reviewed annually.

A program consultant generally selects at random approximately 30 to 60 medically needy and medically indigent cases for review during a field visit.* Since the department does not conduct any other review of the medically indigent adult category, these reviews provide important data about the errors in determining eligibility that occur in this aid category. The consultant reviews an entire case both for procedural compliance and for accuracy in determining eligibility.

The County Liaison Section is not, however, completing the required case reviews as scheduled. For example, the County Liaison Section does not review cases in Los Angeles County because Los Angeles County administers a local quality-control program. During 1981, the County Liaison

* The department's "Quarterly Program Compliance Visit Plan" requires the consultant to visit each county every quarter and review at least 12 cases per visit. The consultants should review more cases in large counties.

Section completed no case reviews in Sacramento County (a large county) and Monterey County (a small county), although it reviewed 1,243 cases in another 47 counties from October 1980 through September 1981.* In 1980, the County Liaison Section reviewed only 24 cases each in Monterey and Sacramento counties, and it reviewed no cases in these counties in 1979. According to the department's criteria, the County Liaison Section should have reviewed at least 48 cases each year in Monterey County and more than 48 cases each year in Sacramento County.

When the County Liaison Section has conducted case reviews, it has detected procedural problems, incorrect application of the regulations, problems with the system, and major errors in determining eligibility. For example, during a review of one county in April 1981, the program consultant found that the county did not use the correct procedures in obtaining consent from minors for certain medical services that do not require a parent's permission. In another county, in June 1981, the consultant found an error in the way the county computed the incomes of applicants. Consultants provided informal training for the county staff to correct both of these problems. In July 1981, a consultant reviewed 41 cases in a county and found major errors involving three cases in which

* The terms "large" and "small" refer to the size of a county's caseload.

the county failed to account for excess property in determining eligibility. Subsequently, the Department of Health Services provided training to county staff to correct these problems.

The County Liaison Section did not complete its case reviews in all counties as scheduled because of the employee turnover rate and because of changes in priorities. Consultants are usually employed for four to five months before they independently conduct field visits and case reviews. Because of a significant turnover of personnel, however, the program consultants assigned to Monterey County and Sacramento County in 1981 were not with the section long enough to conduct any case reviews. Furthermore, the department is placing priorities on other projects, such as conducting the training necessary to implement regulations altered by recent legislation. Because the County Liaison Section has not completed its case reviews as scheduled, errors such as those discussed above may be going undetected.

The department also uses the case reviews completed by the Quality Control and Evaluation Branch (branch) to supplement its monitoring program. The branch conducts federally mandated case reviews for the Medicaid Quality Control program.* Each month the branch staff randomly select

* Medicaid is the title of the national health-care program. California's health-care program is called Medi-Cal.

for review a predetermined number of cases from the statewide eligibility file. Staff members review each case for errors made by eligibility workers and visit the beneficiary's home to verify the living situation. In addition, branch staff contact banks and other third parties to verify the beneficiary's reported financial resources.

The Quality Control and Evaluation Branch also reviews some Medi-Cal cases involving federal funds (AFDC recipients and SSI/SSP recipients) in addition to the cases involving medically needy and medically indigent children. However, the sample used by the branch does not include any medically indigent adults, whose cases are funded entirely by the State. Furthermore, the size of the samples has not been sufficient to enable the branch to determine valid error rates for each individual county. As a result, the State has been limited in its ability to monitor counties and to help them correct problems.

These limitations in the federally mandated case reviews have led to a need for an expanded quality control program. In response to this need, the Legislature recently enacted Assembly Bill (AB) 251, (Chapter 102 of the Statutes of 1981), which requires the Department of Health Services to conduct quality control reviews using statistically valid samples of beneficiaries in each county, including the

medically indigent adult population. The benefits of acquiring data from each county have been demonstrated in Los Angeles County, which started a quality control pilot project in 1979. By concentrating on acquiring data and developing corrective action for each district, this pilot program has identified problems and has reduced the error rates both for cases and for actual dollar payments.*

State quality control reviews have found that Los Angeles County's dollar-payment error rate is considerably below the statewide dollar-payment error rate. Los Angeles County officials attribute this lower error rate to an effective county quality control program. By establishing data for each county and recommending effective corrective action, the department's expanded quality control program would help achieve similar low error rates throughout the State.

To comply with the requirement of AB 251, the department plans to add 19 staff positions and review more medically needy and medically indigent cases annually in the 16

* Dollar-payment errors represent actual misspent dollars resulting from a case error. For example, if the county calculates the beneficiary's share of cost incorrectly, a case error would result. But if the beneficiary did not use Medi-Cal benefits, no dollar-payment error would result. Dollar-payment error rates, therefore, are generally lower than case error rates.

largest counties. The Medi-Cal beneficiaries in these 16 counties constitute 80 percent of the total beneficiaries in the State. In the remaining 42 counties, the department will review a small number of cases involving medically indigent adults and prepare written reports with recommendations for improvement. In addition to conducting case reviews, the department plans to conduct management reviews in all counties. These reviews will evaluate the training of eligibility workers, the counties' interpretations of state eligibility regulations, the counties' supervision of eligibility workers, and the elements of the counties' data processing systems that affect eligibility.

For each of the large counties, the department will report case error rates and the results of the management review. If a county's error rate exceeds 7 percent, the report will include a section on the causes of errors and make specific recommendations for corrective action. The planned date for establishing maximum dollar-error rates is July 1, 1983.

The department began fieldwork for the expanded quality control program on April 19, 1982. However, staffing difficulties caused by the recent statewide personnel freeze

will delay full implementation of the program. According to quality control officials, two major weaknesses in implementing the expanded program are tight scheduling and limited staffing.

With or without the delayed implementation of the expanded quality control program, the department's planned quality control procedures do not fully meet the criteria set forth in AB 251. The bill states that the department shall institute a quality control program for determining eligibility, with on-site state auditors who will verify the determinations of eligibility for a statistically valid sample of applicants in each county. However, the department's quality control program will report statistically valid data for only the 16 largest counties because of staffing limitations imposed by the Department of Finance.

Even though the department's procedures will not fully comply with AB 251, the expanded quality control program is an improvement over the current program. The medically indigent adult cases will now be reviewed for the first time on a statewide basis. The expanded quality control program will also provide reliable data for the 16 largest counties. Furthermore, the program will assemble data from all counties, describing common causes of errors, providing recommendations for corrective action, and establishing a maximum dollar-error

rate by July 1, 1983. And finally, the management survey will correlate exemplary county procedures with reduced errors, helping to demonstrate how certain counties maintain low error rates.

A REVIEW OF THE SPECIAL INCOME DEDUCTION MAY BE WARRANTED

Medically needy persons include aged, blind, or disabled persons who are eligible for a special income deduction that may reduce the beneficiary's share of cost. While this deduction is intended to provide equity between SSI/SSP grant recipients and the medically needy, the federal government contends that the special income deduction does not comply with federal requirements. Based on this interpretation, federal quality control reviewers count as an error any case containing the special income deduction. Consequently, this interpretation increases the State's error rate and has resulted in the potential disallowance of approximately $11 million in federal funds. According to department analysts, the special income deduction affects an estimated 31,540 aged, blind, or disabled medically needy individuals and costs the State $18.9 million.

In 1976, the California Legislature passed a bill that established the special income deduction for medically needy persons who are aged, blind, or disabled. In effect, the

special income deduction protects a portion of the medically needy beneficiary's income so that he will have the same amount of money for nonmedical living expenses as he would have if he received the SSI/SSP cash grant.

For example, Beneficiary X is single, 70 years of age, and receives an SSI/SSP grant. X would automatically receive Medi-Cal with the cash grant. Another individual, Beneficiary Y, is also single and 70 years of age but receives a private pension of $450 per month. Y's income exceeds the limit for receiving a cash grant. Since Y does not receive a cash grant, Y does not automatically receive Medi-Cal. Without the special income deduction, Benficiary Y would have to pay all of his or her income over the amount allowed for living expenses toward medical care before receiving Medi-Cal benefits. The following table details the two cases.

TABLE 3

ANALYSIS OF THE SPECIAL INCOME DEDUCTION IN HYPOTHETICAL CASES

	Beneficiary X	Beneficiary Y	
	SSI/SSP Medi-Cal	Without Special Income Deduction	With Special Income Deduction
Income:			
Private pension	--	$450	$450
SSI/SSP award	$439	--	--
Less:			
Special income deduction[a]	0	--	$130
Allowance for living expenses	0	$309	$309
Share of cost[b]	0	$141	$ 11
Available income for non-medical living expenses[c]	$439	$309	$439

[a] The amount of the special income deduction will vary with the size and composition of the family unit.

[b] Share of cost represents the amount the beneficiary must pay or be obligated to pay for medical care before receiving Medi-Cal benefits.

[c] The available income for non-medical living expenses is determined by deducting the share of cost from the total income available.

As the table shows, X and Y, with the special income deduction, both have $439 to spend on nonmedical living expenses; however, with no special income deduction available, Y has only $309 available for living expenses. The purpose of the special income deduction, then, is to establish equity between SSI/SSP cash-grant recipients and the medically needy persons who are aged, blind, or disabled.

The Special Income Deduction Contributes to Error Rates

According to federal officials, the special income deduction does not comply with federal regulations. Based on this interpretation, federal quality control reviewers count as an error any case containing the special income deduction when the deduction affects a beneficiary's share of cost. Consequently, this interpretation increases the State's error rate and results in the potential disallowance of federal funds.

In order to determine federal error rates, federal quality control analysts select and review a subsample of cases that the department's quality control staff has reviewed. Cases containing a special income deduction that reduces the amount that the beneficiary must pay for medical care before receiving Medi-Cal are counted as errors in the federal quality control review. Any errors identified by federal analysts that

state reviewers did not identify are used to estimate the incidence of errors in all the cases that have been reviewed by the State.

Although the State has disputed the federal error rate results, federal officials have not revised their quality control procedures. Consequently, the State is faced with the potential disallowance of federal funds. The federal Medicaid Quality Control Report, covering the period from April through September 1980, indicates that California exceeded the 5 percent target error rate and is subject to a possible loss of $11 million in federal funds. According to federal officials, the built-in contribution of the special income deduction to California's error rate will become increasingly critical as the State attempts to comply with recently passed federal legislation that requires all states to achieve a maximum error rate of 4 percent by 1983.*

The federal Medicaid Quality Control Report asserts that California's Medicaid error rate for April through September 1980 was 7 percent. During this review period, federal quality reviewers considered California's allowance of the special income deduction to be an error. State quality

* This legislation is contained in the Code of Federal Regulations, Title 42, Sections 431.801 and 431.802.

control staff indicate that the difference between the State's interpretation and the federal government's interpretation contributes substantially to California's error rate as calculated by the federal government. In fact, department officials estimate that the elimination of the special deduction would reduce the federally determined error rate for April through September 1980 from 7 percent to 5.5 percent, a figure only marginally above the target error rate.

Although eliminating the special income deduction would significantly reduce the federal Medicaid quality control error rate, it would also increase the amount that certain medically needy aged, blind, and disabled persons would have to pay for their medical care before being eligible for Medi-Cal. The elimination of the special income deduction could affect approximately 31,540 aged, blind, or disabled persons in the medically needy category.

The State's decision to provide the special income deduction has increased program costs as well as the federally determined error rate. A study prepared by the Fiscal Forecasting Section of the Department of Health Services concluded that the annual savings resulting from the elimination of the special income deduction would be about $34 million. About $18.9 million of this savings would be in the General Fund. The estimated annual savings represents a

combination of program savings totaling $31.4 million ($17.2 million in the General Fund) and county administrative savings totaling $2.6 million ($1.7 million in the General Fund).

CONCLUSION

The State spends most of its Medi-Cal budget to pay for medical services provided to beneficiaries. By making changes in policies and methods that the State and counties currently use to determine eligibility for medical-assistance-only beneficiaries, the State could reduce the number of errors in determining eligibility, reduce expenditures for associated medical services, and avoid potential federal disallowances.

In determining eligibility, some counties are making significant errors that could be reduced if the counties complied with regulations pertaining to the verification of beneficiaries' incomes. The State could further minimize expenditures for ineligible individuals if it reduced the amount of time in which beneficiaries are allowed to provide verification of income.

The State's monitoring program has not conducted the necessary case reviews that guide the technical assistance which the department provides to counties. Such reviews and assistance are important to eliminating deficiencies in the county programs.

A statutory change could also reduce program expenditures. The State currently provides a special income deduction to certain medically needy persons that does not comply with federal regulations and that may result in the federal government's disallowing millions of dollars in federal funding.

RECOMMENDATION

We recommend that the Department of Health Services strengthen the regulations pertaining to eligibility by requiring counties to verify accurately the income of applicants within the 60-day time period. Additionally, the department should review the appropriateness of the 60-day time period and determine whether regulations should be changed to reduce this time period to decrease the potential for ineligible individuals to receive medical services. The department should also improve its monitoring of

counties by conducting more case reviews. If insufficient resources are available, the department's staff should give priority to the largest counties and the counties that are known to have problems in determining the eligibility of applicants.

Finally, the Legislature may wish to review the possibility of eliminating the special income deduction to avoid possible disallowances of federal funds.

CHAPTER II

THE BENEFITS AND COSTS OF QUARTERLY REPORTING ARE IN QUESTION

The eligibility of the Medi-Cal applicants and beneficiaries constantly changes because of mobility, employment, and other factors. Consequently, the Department of Health Services (department) attempts to ensure that individuals who no longer qualify for the program are removed from the eligibility list. The State requires counties to obtain information at least quarterly about changes in a beneficiary's income, living arrangements, and other items that could affect either the status of a beneficiary's eligibility or the beneficiary's share of cost. Based on this quarterly information, counties revoke the eligibility both of beneficiaries who fail to return the status report and of beneficiaries whose changed status renders them ineligible. The counties also use the quarterly information to revise a beneficiary's share of medical costs according to changes in income, resources or expenses.

Los Angeles County discontinued processing quarterly status reports in 1981, claiming that the cost of processing the reports exceeded their benefit. It has proposed an alternate method that appears to be as effective as quarterly

status reporting in discontinuing the eligibility of beneficiaries. However, this alternate method, a mailer, makes no provision for collecting information about changes in a beneficiary's income and expenses. Such changes can affect the share of cost. The quarterly status reports, however, do acquire information that is used to revise the beneficiaries' share of cost. Insufficient information and analysis are available to determine if the cost of obtaining this information exceeds its benefit.

Effective October 1, 1978, the department adopted regulations requiring counties to obtain status reports from current Medi-Cal beneficiaries at least quarterly. The objective of these quarterly status reports is to control program costs by ensuring that Medi-Cal beneficiaries continue to meet the criteria for eligibility. Quarterly status reports help provide counties with sufficient information to discontinue the eligibility of those individuals who no longer qualify for Medi-Cal. The reports also provide the information necessary to revise a beneficiary's share in medical costs according to changes in income, resources, and expenses.

All medically needy and medically indigent beneficiaries except aged, blind, or disabled persons must report any changes in their family size, living arrangements, income, employer, or insurance. The beneficiary may also use

the report to request that Medi-Cal eligibility be discontinued. When a beneficiary returns the status report, an eligibility worker reviews it, checks it against data in the case file for any discrepancies, and takes the necessary action on any reported changes. To ensure that beneficiaries comply with the reporting requirement, the State requires a county to discontinue the eligibility of beneficiaries who do not return the quarterly status report.

Los Angeles County began requiring status reports in April 1979. However, it is not currently processing quarterly status reports. Although the State did not formally grant a waiver, Los Angeles County suspended processing quarterly status reports for the period from January through May 1981. The county resumed processing the reports in June 1981 for one month and it concurrently requested a permanent waiver because of its projected budget reduction. As of February 5, 1982, the State had denied the county's request, but it is negotiating with the county to resolve the problem. The State permitted the county to test an alternate system for monitoring beneficiaries.

Los Angeles' System May
Effectively Discontinue Eligibility

Los Angeles County contends that the cost of processing quarterly status reports outweighs their benefit. The county argues that the only economical benefit of quarterly status reports is the discontinuance of eligibility when beneficaries fail to return the report. To achieve the same benefit, the county proposed using a "reconciliation mailer," which is a one-page notice that requests the beneficiary to indicate his or her desire to continue receiving Medi-Cal benefits. The mailer also reminds the beneficiary to report any changes in status immediately. Clerical employees, instead of eligibility workers, process this mailer. If a beneficiary reports any changes or requests the discontinuance of Medi-Cal coverage, the clerical employee refers the information to an eligibility worker for further processing.

Under the interim agreement with the State, Los Angeles County processed its first reconciliation mailer in February 1982. The county sent mailers to 102,986 cases whom the county would normally have required to return a status report. Eighteen percent of these cases (18,373) were discontinued because they failed to return the mailer. Our review of cases in Monterey County and Sacramento County, which use the regular quarterly status report, indicated similar results based on a single mailing of this report. We project

that of those beneficiaries required to return a status report, at least 31 percent in Monterey County and 12 percent in Sacramento County would have been discontinued because they failed to return the status report.*

Besides discontinuing eligibility when beneficiaries fail to return status reports, counties may also discontinue eligibility according to the information reported on the returned status reports. Counties discontinue eligibility when a beneficiary requests discontinuance or when a beneficiary's circumstances have changed so that he or she is no longer eligible for the program. However, the counties discontinue only a small percentage of cases for these reasons. Our case reviews indicate that at least 1 percent of the cases in Monterey County and 3 percent of the cases in Sacramento County were discontinued as a result of information reported in the quarterly status report. Similarly, Los Angeles County discontinued 1 percent of its cases as a result of information obtained in the reconciliation mailer. Therefore, the reconciliation mailer proposed by Los Angeles County may be as effective as the quarterly status report in identifying beneficiaries whose eligibility should be discontinued either because they fail to respond or because their circumstances no longer qualify them for the Medi-Cal program.

* These figures are based upon a 95 percent level of confidence.

Table 4 summarizes the data accumulated in our case reviews and compares it to the results of Los Angeles County's first reconciliation mailer. The percentages are of the total number of beneficiaries required to respond, and we based the percentages on statistical projections that are at the 95 percent level of confidence.

TABLE 4

COMPARISON OF DISCONTINUED MEDI-CAL ELIGIBILITY RESULTING FROM THE QUARTERLY STATUS REPORT AND THE RECONCILIATION MAILER

	Percent of Cases Discontinued		
	Quarterly Status Reports		Reconciliation Mailer
Reason For Discontinuing Eligibility	Monterey County	Sacramento County	Los Angeles County
Failure to return status report	31%	12%	18%
Change in status	1%	3%	1%

In general, our test of cases in Monterey County and Sacramento County indicates that the quarterly status reports produced results that are similar to those that Los Angeles County produced with its first reconciliation mailer.

Costs and Benefits of
Collecting Information
Pertinent to the Share of Cost

Increases or decreases in income can cause a change in a beneficiary's share of medical costs. Beneficiaries may report such changes in their income and expenses on the quarterly status report. However, Los Angeles County's proposed reconciliation mailer contains no provision for reporting this type of information.

Nevertheless, the benefits derived from processing the quarterly status report only to obtain information on changes in a beneficiary's income and expenses may still be less than the administrative cost of collecting the data. Our case reviews indicate that while 10 percent or more of the status reports may contain useful information, up to 90 percent of the reports may not result in any changes at all. For example, in Sacramento County, we estimate that at least 10,435 beneficiaries returned status reports. At least 1,252 of these reports (12 percent) contained changes that were significant enough to change the beneficiary's share of cost. In Monterey County, the estimated number of beneficiaries required to return status reports (at least 2,903) was smaller, yet only 10 percent or 290 of these cases contained significant changes. Furthermore, because all eligible beneficiaries do not always use their Medi-Cal benefits, the information obtained from

quarterly status reports that leads to changes in beneficiaries' status may not have a significant impact on program costs. However, the counties incur administrative costs for every status report that is returned, because all the reports must be reviewed.

None of the three counties we reviewed could accurately estimate the cost of processing the quarterly status reports. Further, Los Angeles County's data appear to be insufficient to support the county's contention that the quarterly status report is not economical. To support its position, Los Angeles County cites the results of a quality control review made in March and April of 1981. This review identified errors made in processing quarterly status reports; however, it did not measure the number of times beneficiaries reported a change, nor did it measure the effect of those reported changes.

The Savings Achieved By the Reconciliation Mailer May Be Overstated

Los Angeles County estimates that it would save $4.5 million by substituting the reconciliation mailer for the quarterly status report. However, certain weaknesses exist in the basis for this estimate. First, the county adjusted its objectively established workload standards. Second, the county

compared the cost of processing the mailer once a year to the cost of processing the quarterly status report three times a year. Therefore, Los Angeles County overestimated the savings attributable to using the reconciliation mailer instead of the quarterly status report.

In January 1980, Los Angeles County conducted a study to establish objectively the number of cases that an eligibility worker should handle. (This study was based on an internationally approved work measurement system.) When the county elected to discontinue quarterly reports, however, it adjusted the standard caseload per worker by deducting an estimated amount of the worker's time that represented time spent processing the status reports. The county then estimated the increased number of cases each worker could handle if that worker were not processing quarterly status reports.

The county plans to send out and process the reconciliation mailer only once each year, whereas the quarterly status report is processed three times yearly.* Because the status of Medi-Cal applicants and beneficiaries changes constantly, status reports may in fact be needed quarterly to keep up with these changes; annual mailings might

* The annual review of eligibility serves as the fourth contract with the beneficiary and justifies using the term "quarterly report."

not provide nearly the benefits that quarterly reporting provides. Therefore, in order to estimate savings properly, the county should base its calculations on the results of three mailings.

Los Angeles County and the State Department of Health Services are working together to develop the most effective process for reporting income and status changes. The county is sending another mailer to all but 399 of the 102,000 beneficiaries remaining on the rolls after the February mailing. The 399 who were selected at random will receive only the quarterly status report. The county will compare the results of the mailer with those of the quarterly status report to assess the effectiveness of the reconciliation mailer.

CONCLUSION

Los Angeles County is not processing the quarterly status report as required by the Medi-Cal regulations. The county has proposed an alternate method of monitoring, the reconciliation mailer, which the county claims is as effective as the quarterly status report but less costly to administer. Our review showed that the mailer may be effective as the quarterly status report for discontinuing the eligibility of beneficiaries.

However, the reconciliation mailer contains no provision for reporting changes in income, resources, or expenses that lead to revising a beneficiary's share of cost. The quarterly status report may not be economical for this purpose, but sufficient information and analysis are not available to support the use of either the mailer or the quarterly status report.

RECOMMENDATION

Before concluding its negotiations with Los Angeles County, the Department of Health Services should obtain sufficient data to determine and evaluate the costs and benefits of the quarterly status report in obtaining information that warrants revising a benficiary's share of cost. The department could then determine if the costs of processing the quarterly status reports exceeds the benefits. Any alternate system that the department considers approving should maintain sufficient contact with beneficiaries.

Further, the department should consider revising the quarterly status report so that its benefits can be achieved for the lowest administrative cost. Until the appropriate data are obtained and analyzed, the department should require Los Angeles County to continue processing quarterly status reports as required by the Medi-Cal regulations.

CHAPTER III

DUPLICATION AND INEFFICIENCY IN LOS ANGELES COUNTY INCREASE MEDI-CAL ADMINISTRATIVE COSTS

In addition to paying for medical services provided to medical-assistance-only beneficiaries, the State also spends more than $100 million a year to administer the portion of the Medi-Cal program that provides services to these medically needy and medically indigent beneficiaries. Since 1972, the department has reimbursed Los Angeles County for the costs associated with administering two separate systems for determining the eligibility of medically needy and medically indigent beneficiaries.

The Los Angeles County Department of Health Services operates one system, processing applications taken from individuals admitted to the county hospitals. The Department of Public Social Services (DPSS) administers the other system, processing Medi-Cal applications in its district offices. Both of these departments conduct a supervisory review of the determinations of eligibility that the hospital workers make. No other county conducts two such supervisory reviews of cases.

The Los Angeles County Department of Health Services is significantly less efficient than the DPSS is in processing Medi-Cal applications. However, the State does not employ productivity requirements in calculating the amount that the Los Angeles County hospitals are reimbursed for processing applications. The State Department of Health Services could reduce administrative costs by approximately $2.1 million if it did not reimburse Los Angeles County for the extra supervisory review.

THE STATE COULD REDUCE THE REIMBURSEMENT OF LOS ANGELES COUNTY ADMINISTRATIVE COSTS

The State could achieve significant savings if it did not reimburse Los Angeles County for the duplication and inefficiency inherent in the county's present system for determining Medi-Cal eligibility. The Legislature has limited the reimbursements that are made to the Los Angeles County Department of Health Services. However, the State Department of Health Services is still reimbursing Los Angeles County for the excess costs that result from the present system.

History of Los Angeles
County's Two Systems

With the exception of Los Angeles County, each county's social service department is solely responsible for determining if individuals are eligible for Medi-Cal benefits. These social service departments are also responsible for periodically verifying the eligibility of beneficiaries. These departments process all Medi-Cal applications that are submitted in their counties in both the social services offices and the county hospitals. Since county hospitals provide medical services to the medically indigent, some counties assign personnel from the social service departments to county hospitals to determine eligibility for individuals admitted to these hospitals. In Los Angeles County, the Department of Public Social Services (DPSS) processes Medi-Cal applications submitted in its district offices. However, the Los Angeles County Department of Health Services processes Medi-Cal applications from individuals admitted to the county hospitals.

Before 1971, medically indigent persons in California generally were treated in county hospitals, and some counties billed Medi-Cal for the costs of treating this group of patients. The Medi-Cal Reform Act of 1971, however, required the counties to determine the eligibility of each medically indigent person individually. As a result of this act, DPSS

employees in Los Angeles County were assigned to the county hospitals to process Medi-Cal applications. The DPSS employees were responsible for determining eligibility, while hospital employees were responsible only for hospital functions. Although the DPSS employees were assigned to the hospitals, the DPSS management was still responsible for them.

Soon after the DPSS began processing Medi-Cal applications in the county hospitals, Los Angeles County became concerned that this system was creating major problems in management and staffing. The county was also concerned about the severe loss of revenue resulting from the insufficient number of Medi-Cal applications being processed by DPSS employees. The system required an elaborate division of responsibilities to ensure that the processing of Medi-Cal applications and the hospital functions were kept separate. This division resulted in numerous meetings with patients and in a duplication of effort because eligibility workers had to interview patients to determine eligibility and hospital workers had to interview patients to obtain billing information and medical insurance assignments.

Further, the hospital management experienced problems with the system because it had no control over the Medi-Cal application process, even though potential Medi-Cal patients

constituted a significant portion of the county hospitals' workload. Hospital officials stated that the county experienced a severe loss of revenue from the Medi-Cal program because DPSS employees were not aggressive in verifying the eligibility of patients.

In 1972, Los Angeles County established a task force to evaluate the effectiveness of the system and to recommend changes. The task force recommended that the hospitals implement a new system for determining Medi-Cal eligiblity in the county hospitals. The new system, which was approved by both the state and the federal government, allowed hospital employees to process Medi-Cal applications for patients admitted to the county hospitals. Under this agreement, the Los Angeles County hospitals were also allowed to bill the State for the cost of processing the Medi-Cal applications.

The hospital employees who processed Medi-Cal applications determined eligibility and also performed hospital functions. Hospital functions are those duties performed for all hospital patients, including financial screening, preparing billing instructions, and obtaining insurance assignments. Determining eligibility entails the duties that the DPSS employees had previously performed; these duties pertain only to the processing of Medi-Cal applications. Although hospital

employees initiate and process the Medi-Cal applications, the system approved by state and federal officials requires applications to be reviewed and certified for eligibility by a DPSS supervisor, who is known as a "hospital certifier." The DPSS supervisors make the final determination of eligibility.

The Two Systems Duplicate Supervisory Reviews

Both the DPSS and the Los Angeles County Department of Health Services conduct a supervisory review of every case processed in the hospitals because the agreement that initially permitted hospital employees to process Medi-Cal applications also required DPSS personnel to decide on eligibility. Further, the agreement specified that DPSS workers would supervise the Medi-Cal processing functions of hospital workers.

Currently, every Medi-Cal application processed at the county hospitals undergoes two separate supervisory reviews. The hospital employees are responsible for processing the Medi-Cal applications, and once a case is complete, the supervising hospital employee reviews it to ensure that the eligibility has been determined correctly. After this review, a DPSS supervisor reviews the case. This additional review is not required of Medi-Cal cases processed at DPSS district offices, nor is it required in other counties.

The DPSS employs 41 supervisors to certify Medi-Cal cases in the county hospitals.* It claims the cost of these supervisors and is reimbursed by the State. The cost for these supervisors in fiscal year 1981-82 is estimated to be $2.1 million.

The DPSS has calculated the average budgeted cost of the supervisor's and eligibility worker's position. This average includes the salary and benefits of the employee as well as the indirect costs, such as the cost of clerical and management employees, travel, data processing, and the supplies necessary to support this position. According to the DPSS staff, this amount is approximately $52,000 per worker per year. Based on this amount, the 41 supervisory positions will cost approximately $2,132,000 in fiscal year 1981-82.

The State Pays for the Inefficiency of the Los Angeles County Hospitals

Like other county social service departments, the DPSS is subject to the State's cost control plan. This plan, which the State Department of Health Services developed, limits the reimbursement of county administrative costs and sets

* The DPSS employed 41 supervisors as of March 23, 1982. However, this number may fluctuate with changes in workload levels.

workload standards for processing Medi-Cal applications. Under this cost control plan, counties are divided into groups according to population. Standards developed for each group are based on the average level of productivity of the counties within each group. Counties that fail to meet this standard must submit a plan of action to increase their productivity to meet the standard.

The State's cost control plan has reduced the rate of increase of county administrative costs. Whereas administrative costs were increasing by about 30 percent per year before 1977, these costs increased by only 9.9 percent in fiscal year 1977-78. Administrative costs increased by only 1.1 percent in fiscal year 1978-79.

The State measures productivity each quarter to ensure the appropriate level of reimbursement for determining eligibility. In determining workload standards, the State has grouped the Los Angeles County DPSS with the very large counties. Currently, DPSS eligibility workers are required to process 58 Medi-Cal applications per month; the average processing cost for an application is approximately $83.

Los Angeles County Department of Health Services employees in the hospitals are not as efficient as the DPSS is in processing Medi-Cal applications. The county hospitals process fewer applications per worker than the DPSS, causing the processing cost of an application to be much greater than it is at the DPSS. In fiscal year 1980-81, the hospital employees processed approximately 35,500 Medi-Cal applications at an average of 16 applications per month and at a cost of approximately $338 per application. This amount is about $255 more than the DPSS' average processing cost per application.

The Los Angeles County hospitals are not subject to the State's cost control plan. However, the Legislature has limited the reimbursement of Los Angeles County's hospital administrative costs in each of the last two budget acts. In the 1980-81 Budget Act, the Legislature limited the amount of reimbursement to $253 per application. It thereby limited the total reimbursement to $7.6 million even though the hospitals had asked the State for a $12.0 million reimbursement. In the 1981-82 Budget Act, the Legislature imposed more restrictive limitations upon the hospitals. Specifically, the Legislature further reduced the amount of reimbursement to $162 per application and limited the number of applications for which it would reimburse the hospitals to 31,582. Consequently, the Los Angeles County hospitals' total reimbursement is limited to $5.1 million.

Although the Legislature has limited the reimbursement of administrative costs it will make to the Los Angeles County hospitals, the State has not required the hospitals to meet any productivity standards. Consequently, the county has not developed work standards that would reflect the actual amount of time required to process Medi-Cal applications in the county hospitals. Thus, the hospitals have little incentive to operate at top efficiency.

Hospital officials state that Medi-Cal applications cannot be processed as efficiently in hospitals as in the DPSS district offices. In the hospitals, the worker must go to the wards to interview sick patients and assist them in completing the application forms. Often, the worker may have to return two or three times because the patient is receiving medical attention while the interview is taking place. In the district offices, Medi-Cal applicants first complete the application form and then submit it to the DPSS worker for review and approval. Consequently, processing an application takes more time in the hospitals than it does in the DPSS offices.

Although processing an application takes more time in the hospital than it does in the DPSS offices, hospital workers in counties comparable to Los Angeles County process more

applications per worker than the Los Angeles County average of 16 applications per month. For example, in four very large counties, workers stationed in county hospitals processed from 24 to 42 cases per month. The average number of cases processed in these four counties was 34. Furthermore, some of the Los Angeles County hospital workers believe that higher productivity levels are possible, and they indicated that they could process between 40 and 50 applications per month.

Because the State did not require the Los Angeles County hospitals to process applications at a rate comparable to other counties, the State reimbursed the Los Angeles County hospitals for an additional $145,000 in fiscal year 1980-81. During that year, Los Angeles County could have processed approximately 35,500 hospital applications more efficiently if it had been subject to productivity requirements similar to those imposed upon the DPSS and other counties. Although the county should develop its own engineered work standards, the productivity of other counties indicates that workers could have processed more cases.

If the Los Angeles County hospital employees had processed cases at an average rate comparable to the rates in the four counties we contacted, the hospitals would have significantly reduced administrative costs. For example, if

hospital employees had processed 32 cases per worker per month, or twice the number of cases that they processed during 1980-81, 92 workers processing cases full time would have been needed to process the 35,500 cases in Los Angeles County. The Los Angeles County hospitals actually employed 184 workers during that period to process Medi-Cal applications.* In addition to these employees, of course, clerical positions and supervisors were needed to process applications. A higher productivity in processing applications would have reduced the total number of staff needed to process applications. We estimate the savings in salaries and benefits associated with this reduction in staff to be $4,068,000. In addition to savings resulting from fewer employees, a proportional reduction in other expenses, such as salaries for management personnel, would occur. We estimate these savings to be $458,000.

Therefore, if the Los Angeles County hospitals' productivity was comparable to that of other counties, their total administrative costs would have been reduced by $4,526,000 ($4,068,000 plus $458,000). Subtracting this amount from the $12,011,000 claim that the hospitals submitted to the

* This number is an estimate of the full-time equivalent eligibility-worker positions that were required to process applications in 1980-81.

State shows that the reimbursement should have been $7,485,000. The Legislature had limited the hospitals' reimbursement for administrative costs to $7,630,000 in 1980-81. Thus, if the State had reimbursed the Los Angeles County hospitals according to a productivity standard comparable to other very large counties, it could have reduced the administrative costs that it reimbursed by approximately $145,000.

In 1981-82, the Los Angeles County hospitals' earlier inefficiency in processing of Medi-Cal cases will probably not result in additional costs to the State. First, the Legislature has reduced the hospitals' reimbursement from $253 to $162 per application. Second, the hospitals are processing more cases than in 1980-81. Hospital officials estimate that in 1981-82 they will process approximately 52,000 applications; however, the State will reimburse the hospitals for the processing costs of only 31,528 cases.

We were unable to determine if the Los Angeles County hospitals' earlier inefficiency in processing Medi-Cal applications will inflate future reimbursements by the State for administrative costs. If the Legislature maintains its present limit on the reimbursements and if the hospitals continue to process at least 31,582 applications per year, the State will not be reimbursing the hospitals for costs resulting

from the inefficient processing of applications. However, if the State does not require the hospitals to meet an appropriate productivity standard for processing applications, it may reimburse the hospitals for excessive costs. Further, a decision by the State either to raise the budget limit for the Los Angeles County hospitals or to discontinue the limitation of reimbursements could result in excess reimbursements. Also, if the hospitals process fewer applications while maintaining the current number of positions, the State could make excess reimbursements.

CONCLUSION

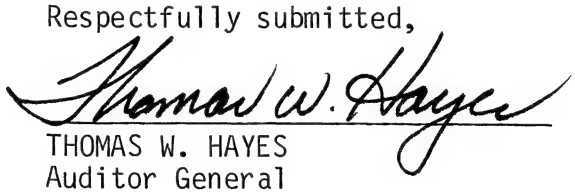
Since 1972, the State Department of Health Services has reimbursed Los Angeles County for costs associated with administering two systems for determining Medi-Cal eligibility. These two systems create duplication because both the Los Angeles County Department of Health Services and the Department of Public Social Services conduct supervisory reviews of the determinations of eligibility that the hospital workers make. Also, the State has in the past reimbursed the hospitals for inefficiencies in processing applications. If the State stopped reimbursing Los Angeles County for

the additional costs of maintaining two systems to determine eligibility, it could save an estimated $2.1 million.

RECOMMENDATION

The Department of Health Services should develop a method for reimbursing Los Angeles County that does not subsidize the duplication and inefficiency created by the county's present system for determining eligibility. Specifically, the department should not reimburse Los Angeles County for two different supervisory reviews of applications processed by the hospitals. The department should also require Los Angeles County to prepare engineered work standards for hospital workers. These standards should serve as a basis for controlling reimbursements paid by the State.

Respectfully submitted,



THOMAS W. HAYES
Auditor General

Date: May 24, 1982

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STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY EDMUND G. BROWN JR., Governor

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May 19, 1982

Mr. Thomas W. Hayes
Auditor General
660 J Street, Suite 300
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Dear Mr. Hayes:

This is in response to your draft report of May 13, 1982, entitled "Medi-Cal Can Reduce Its Program and Administrative Expenditures". Due to the extremely limited time allowed for response we have restricted our reply to the main topics. I believe our response indicates that the Department has recognized many of the same areas where improvement is warranted in the operation of the Medi-Cal determination system. I am happy to report we are already in the process of taking several of the actions recommended in your report.

We would appreciate receiving the criteria used in your case review and a listing of the errors identified. We will work with the counties to take the appropriate corrective action.

My comments on the major subject items are attached.

Sincerely,

Barry L. Dorfman MD for

Beverlee A. Myers
Director

Attachments

RESPONSE TO THE REPORT OF THE AUDITOR GENERAL

ON

"MEDI-CAL CAN REDUCE ITS PROGRAM AND ADMINISTRATIVE EXPENDITURES"

DEPARTMENT OF HEALTH SERVICES

MAY 1982

I. Regulations Governing Verification of Income, Pages 15-20*

II. County Monitoring and Case Review, Pages 21-28*

III. Review of the Special Income Deduction, Pages 29-34*

IV. Quarterly Status Reporting, Pages 38-49*

V. Medi-Cal Eligibility Determination in Los Angeles County, Pages 50-64*

* Page listings identify the subject area pages from the Auditor General's Draft Report of May 13, 1982.

I. Income Verification

One major recommendation of this audit addressed verification of income. The Department's position is that income for eligibility determination purposes be verified prior to granting eligibility. This is contained in the Governor's FY 1982-83 Budget, in the Budget Trailer Bill, and now in proposed legislation (AB3480). The Department has prepared emergency regulations to implement this change if given the statutory authority. The Department will follow up on those "error" cases identified by the Auditor General and take the appropriate corrective action, when a list of such cases is made available.

Current regulations require that any income reported must be verified to ensure continued Medi-Cal eligibility. The Department has previously identified income verification in terms of clarification of actual income reported or received as a problem area and has developed several specific corrective actions. The quarterly status report was the first such item. It was intended to identify, as soon as possible, new income and/or changes in levels of income. Additionally, the Department has been closely monitoring Medi-Cal quality control findings on "income" errors. This information has been passed on to counties for development of county specific corrective action measures. The program consultant staff in the Medi-Cal Eligibility Branch also monitored these findings and in conjunction with the results of state hearing decisions, developed appropriate corrective actions. Finally, the Department has initiated an earnings clearance pilot project (as mandated by 1981 legislation) in which wage/claim files maintained by the Employment Development Department and lists of Medi-Cal applicants and beneficiaries were matched. Since the results of the project appear cost-beneficial, the

system will be expanded to include the entire state in the near future. It is the Department's belief that further administrative efforts to alleviate the income verification problem must be supported by statutory change.

A final general point must be addressed. The report implies that 92 percent of the "cases in error" could be totally ineligible for Medi-Cal. Income, in itself, can never render an applicant/beneficiary of Medi-Cal totally ineligible. Eligibility is based on numerous other factors, while "income" determines only a share of cost amount that an applicant/beneficiary must pay or obligate before receiving Medi-Cal benefits.

II. County Monitoring and Case Review

The report indicates that Medi-Cal program consultants in the Eligibility Branch should be performing more on-site case reviews in county welfare departments and that this would have a significant impact on Medi-Cal eligibility error rates. As noted in your report, the Legislature in June, 1981 enacted AB 251 which, among other items, requires the Department of Health Services to conduct quality control reviews using statistically-valid samples of beneficiaries in each county, including the medically indigent population. By coupling these reviews with the federally-mandated Quality Control program, the Eligibility Branch staff will reduce its emphasis on on-site case reading.

Instead, Medi-Cal program consultants will substantially increase their efforts in the areas of compliance and implementation of new legislative mandates. We expect to be able to enhance our ability to monitor county performance through use of the findings from the expanded Quality Control program. In addition to providing statistically-valid case review findings for specific counties (including Medically Indigent Adult cases), Quality Control staff will also be conducting management reviews of county welfare departments. We expect to achieve more county compliance and error reduction through these mechanisms than through on-site reviews by program consultants.

III. Review of the Special Income Deduction (SID)

The Department of Health Services also recognizes that program costs and the potential for federal sanctions necessitate elimination of the SID currently allowed Aged, Blind and Disabled Medically Needy (ABD-MN) individuals. We believe, however, that the report does not sufficiently explain the reason for the SID nor does it adequately address what impact the elimination of the SID will have on the ABD-MN population.

State statute was amended in 1976 to provide for the SID to insure that all indigent aged, blind or disabled residents of California were treated equally with respect to their eligibility for Medi-Cal. The SID guarantees that any ABD person in need of Medi-Cal will not be disadvantaged if in fact the individual's source of income is other than public assistance. The example on Page 31 of the report illustrates that without the SID, the Medi-Cal beneficiary with a private pension of $450 would have to pay the first $141 in health care costs each month before receiving Medi-Cal covered benefits. On the other hand, the individual with no income of his or her own receives not only the full public assistance grant of $439 each month, but Medi-Cal pays for all his health care costs. Yet, the difference in income of these two individuals is only $11. It is this basic inequity that was addressed in the 1976 statute change (Chapter 126, Statutes of 1976).

Proposed legislation, AB 3480, will do away with the SID by repealing Welfare and Institutions Code, Section 14005.13. Not only will substantial program savings result from the passage of AB 3480, but the possibility of a federal

sanction based on future federal Quality Control review will be eliminated. As the report notes, the Federal Government has indicated that California is out of compliance with federal Medicaid regulations and is therefore subject to a federal sanction which could cost the State millions of dollars. It should be pointed out, however, that the Federal Government initially was accepting of the SID, and has never (since 1976) officially ruled this State out of compliance on the issue until a recent reformat of the State Plan was disapproved by the Department of Health and Human Services based upon the SID.

IV. Quarterly Status Reporting

The Auditor General's contention that Los Angeles County's Purge/Reconciliation (P/R) method may be as effective as QSR in discontinuing the eligibility of beneficiaries cannot be substantiated by the information provided. The report refers to an 18 percent discontinuance as a result of failure to return the P/R mailer. However, because no contact other than the annual redetermination had been made by Los Angeles County for an entire year, comparisons to quarterly contacts probably are not valid.* If quarterly contacts had been made, the overall discontinuance rate could have been considerably higher. The report further indicates the county proposes an annual mailing of the P/R cards. Initially this was the plan, but the county revised its procedures to allow for quarterly P/R mailings at the insistence of the Department of Health Services. At this time, sufficient data are not available to draw accurate conclusions as to the effectiveness of the P/R method compared to QSR.

In order to gather information to evaluate the two methods, DHS and the county have scheduled the following activities:

1. A random sample (400 cases) was selected of case discontinued due to failure to return P/R cards in February, to affect March eligibility.
2. Another random sample (399 cases) was selected to receive QSRs in April, to be returned in May, to affect June eligibility.
3. A third random sample of 400 cases discontinued as a result of the P/R cards issued to the balance of LA County, for June eligibility, was also selected.

* Auditor General Comment: We believe our comparisons are valid because the discontinuances resulting from both the reconciliation mailer and the quarterly status report reflect the status at a specific point in time rather than the cumulative effect over a 12-month period.

4. These three samples will be tracked through both claims payment and eligibility systems to determine:
   a. What claims were paid in the quarter preceding discontinuance.
   b. How many persons reapplied for Medi-Cal in the quarter following discontinuance.
5. A study will be made to arrive at the percentage of persons reporting income changes as a result of the QSR compared to those reporting as a result of the P/R.

When these data are available, we hope to better understand how these two reporting systems affect Medi-Cal users and nonusers and the rate of recidivism. This will assist in any restructuring of reporting requirements.

V. Medi-Cal Eligibility Determinations in Los Angeles County

The Department of Health Services agrees that there should be a unified system for processing Medi-Cal applications in Los Angeles County hospitals. The report does point out that while Patient Financial Services Workers (PFSWs) process hospital applications, the applications must be certified by Los Angeles Department of Public Social Services eligibility supervisors. This provision is required by the Federal waiver allowing PFSWs to process Medi-Cal applications in hospitals. The Medi-Cal State Plan filed with the Federal Government requires that eligibility determinations be made by county welfare departments, thus we would be out of compliance if we allowed hospital supervisors to certify Medi-Cal eligibility (pg. 51).

The Department is attempting to contain costs that result from the present system (pg. 51). In addition to supporting the concept of PSFW workload standards the Department is gathering preliminary information about the appropriateness of having PSFWs Time Studied in the same manner as the Los Angeles Department of Public Social Services staff (pg. 64).

cc: Members of the Legislature
Office of the Governor
Office of the Lieutenant Governor
State Controller
Legislative Analyst
Director of Finance
Assembly Office of Research
Senate Office of Research
Assembly Majority/Minority Consultants
Senate Majority/Minority Consultants
Capitol Press Corps